

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION  
GREEN BAY PLASTIC SURGICAL ASSOCIATES**

**PATIENT INFO:** PLEASE PRINT AND COMPLETE *IN FULL*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Middle Initial Date of Birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Street Address Apt # City State Zip

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Home Phone # Work Phone # Ext

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Doctor Chart #

**AUTHORIZE RECORDS RELEASED FROM:**

Green Bay Plastic Surgical Associates  
704 S. Webster Avenue  
Green Bay, WI 54301  
(Fax # 920-432-7517)

**RECORDS RELEASED / MAILED TO:**

\_\_\_\_\_  
Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Street Address Apt #

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
City State Zip

**TYPE OF INFO TO BE RELEASED:** (PLEASE CHECK **ALL** APPLICABLE CATEGORIES)

_____ ALL INFORMATION	_____ Pictures	_____ Emergency Department Reports
_____ Medical History	_____ Hospital Records/Reports	_____ Copies of all other Reports
_____ Examination & Reports	_____ Laboratory Reports	_____ Other _____
_____ Treatment or Tests	_____ X-Ray Reports	_____
_____ Operative Reports	_____ Prescriptions	_____

**Purpose / Reason for Release:** \_\_\_\_\_

**This Authorization is Effective Until the Following Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Although this effective date may be a future date, we are only allowed by law to disclose information gathered up to and including your signature date. If your intention is to have us include future medical information, please ask for further instructions.)

**I understand that I may revoke this authorization at any time by providing a written revocation.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature (If signed by person other than patient, state relationship below) Date

**Patient Is:**

\_\_\_\_\_ Minor \_\_\_\_\_ Incompetent \_\_\_\_\_ Deceased

**Signatory's Legal Authority:**

\_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Deceased  
Next of Kin

**\*\* This information has been released in accordance with state & federal laws – it contains information that is privileged, confidential, & exempt from disclosure under applicable state & federal law. Unless otherwise authorized by law, this information may not be re-disclosed without further written authorization of the patient. \*\***

- FOR GBPSA USE ONLY -

Verbal Notification \_\_\_\_/\_\_\_\_/\_\_\_\_  
Verified With: \_\_\_\_\_

Records Distributed \_\_\_\_/\_\_\_\_/\_\_\_\_  
MAIL FAX PICK UP OTHER